STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0458	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS A complaint investigation was conducted on 11/04/24 through 11/07/24. Event ID #UEOW11. The following intake was investigated NC00208095. 1 of 1 allegation resulted in a deficiency.	L 000		
L 050	.2210(B) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (b) A facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility's becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). This Rule is not met as evidenced by: Based on staff interviews the facility failed to submit an initial allegation report to the state survey agency for 1 of 1 incident of fraud against the facility. The findings included: On 11/4/24 at 4:45 PM an interview was conducted with the previous Owner/Administrator of the facility. She stated that on 4/6/23 she was notified by the business manager's bank that the bank had frozen the business manager's account due to a suspicious transfer of $100,000. The Owner/Administrator of the facility notified the local sheriff department, and a detective came to the facility on 4/6/23. The local district attorney's office was also involved. On 4/11/23 the case	L 050	The Statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction, the plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. L-050 Reporting, Investigating Abuse, Neglect Corrective action for affected residents On April 6, 2023 the local Police were	11/29/24

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L 050	Continued From page 1 was transferred to the Federal Bureau of Investigation (FBI). The FBI agent assigned to the case spoke to the Owner/Administrator on the phone. At some point the facility Owner/Administrator was instructed by the FBI not to speak about the case with anyone. The FBI agent came to the facility on 4/19/23. The Owner/Administrator of the facility ended up having to hire a forensic detective to retrieve all records of transfers from the business manager's bank account. It took the forensic detective several weeks to gather all the information and that was when they found out that the business manager stole 1.5 million dollars. The facility owner revealed that the monies stolen came out of the main account. The residents' personal monies were kept in a separate account and had not been touched. The facility Owner/Administrator did not call and report the fraud to the Division of Health Service Regulation since none of the money stolen came from the residents' accounts. On 11/5/24 at 10:30 am interview was conducted with the current Business Office Manager. Back in April of 2023 she was managing trust accounts for the residents at the facility. She stated that the accounts are separate from the main facility account and no money had been stolen from the trust accounts.	L 050	notified of a potential violation in the transfer of facility funds. The Business Office Manager was terminated on 4/6/2023. Facility staff responsible for resident funds at the time of the alleged incident determined that resident funds were not affected. No residents were found to be affected by this alleged deficient practice. Corrective Action for other residents having the potential to be affected On 11/7/2024, the Business Office Consultant completed a review of facility and resident funds and results were no misappropriation noted related to facility or resident funds. On 11/26/2024, the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to reporting allegations of abuse per facility policy. The results included: There were no grievances or Resident Council Minutes that included any abuse. This was completed on 11/26/2024. Additionally, on 11/26/2024, the Administrator reviewed all investigation reports submitted to State Survey Agencies for the past 30 days to ensure allegations of abuse submitted per facility policy. The findings included: No other residents were affected by this alleged deficient practice and reports submitted per facility policy. This was completed on 11/27/2024. Measures/Systemic Changes to prevent recurrence On 11/26/2024, the Administrator and Director of Nursing were educated by the Regional Nurse Consultant on regulatory reporting time of two hours for abuse to state agencies. The Administrator and	

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L 050	Continued From page 2	L 050	Director of Nursing was also educated on assigning a backup person for reporting abuse to the state agencies. On 11/26/2024, the Business Office Manager was educated related to reporting any discrepancies related to facility or resident funds to the Administrator immediately. The Regional Nurse Consultant will ensure that any of the above identified staff who does not complete the in-service training by 11/28/2024 will not be allowed to work until the training is completed. This training will be included in new hire orientation for any newly hired staff. In addition, the Corporate Business Office Consultant will continue completing quarterly audits related to facility and residents' funds to ensure funds are being managed properly. Monitoring Procedure to make sure solutions are sustained Beginning the week of 11/26/2024 the Administrator or designee will monitor compliance utilizing the QA Tool for Misappropriation. The Administrator or designee will randomly interview (4) residents and review business office transactions to identify any misappropriation and ensure reported to state reporting agencies per facility policy if identified. This will be completed weekly x 4 weeks then monthly times 2. Monitoring tools will be reported to the Quality Assurance Committee weekly by the Administrator or designee wherein any additional corrective actions will be determined and assigned as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator,	

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L 050	Continued From page 3	L 050	Minimum Data Set Coordinator, Therapy Director, Health Information Manager, and the Dietary Manager Date of Compliance: 11/29/2024	